Nursing & HEALTH CARE

VOLUME 6, NUMBER 4 APRIL 1985

Payoffs of Partnership

Official Publication of the National League for Nursing

Nursing & HEALTH CARE

VOLUME 6, NUMBER 4 APRIL 1985

CONTENTS

Cover Story

Paving the Way to Partnership

Nursing education and nursing service need each other — and when they join forces, patients win too. **Page 188.**

Duane D. Walker

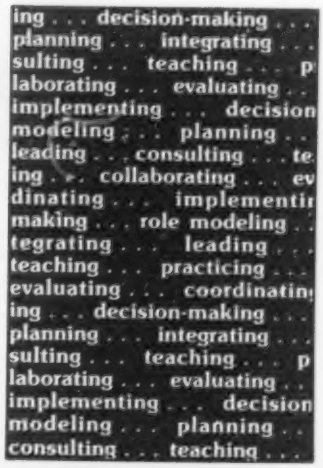
Features

192

Honing Specialists' Leadership Skills

Graduate education must cultivate leadership skills, say the authors, if clinical nurse specialists are to succeed.

Linda C. Hodges
Gaye W. Poteet
Barbara J. Edlund


ing . . . decision-making . . .
planning . . . integrating . . .
sulting . . . teaching . . . p
laborating . . . evaluating . . .
implementing . . . decision
modeling . . . planning . . .
leading . . . consulting . . . te
ing . . . collaborating . . . ev
dinating . . . implementi
making . . . role modeling . .
tegrating . . . leading . . .
teaching . . . practicing . . .
evaluating . . . coordinatin
ing . . . decision-making . . .
planning . . . integrating . . .
sulting . . . teaching . . . p
laborating . . . evaluating . . .
implementing . . . decision
modeling . . . planning . . .
consulting . . . teaching . . .

202

What Role for Nurse Specialists?

The authors used a survey to key in on the behaviors that make clinical nurse specialists special.

Mary Ellen A. Wyers
Susan K. Grove
Cynthia Pastorino

198

Caring for Low-Birthweight Babies

As technology improves — and costs soar — these ideas on how to apportion resources to care for LBW infants are worth thinking about.

Marianne Roncoli
Dorothy Brooten

208

A Theory of Nursing

This researcher looks at care across varying cultures.

Madeleine M. Leininger

Departments

175 Guest Editorial
176 Announcements
177 NLN Perspective
183 News
186 Washington Focus
213 Accredited AD Programs
218 Proposed Resolutions
225 Consumer Capsules
226 NLN Calendar
227 Classified

NURSING & HEALTH CARE offers diverse views on subjects of interest to readers. Articles represent the opinions of individual contributing authors and are not necessarily those of the National League for Nursing.

Clinical Nurse Specialist: In Search of the Right Role

MARY ELLEN A. WYERS
SUSAN K. GROVE
CYNTHIA PASTORINO

Defining the clinical nurse specialist (CNS) role has been fraught with confusion, frustration, and conflict. Nurses, especially nurse administrators, graduate nurse educators, and clinical nurse specialists, are struggling to pinpoint the role and to establish it more firmly. But even in the midst of struggle, these groups look optimistically at the potential effects of the CNS role on health care delivery and continue to try to evaluate and clarify that role. Each group sees the role from their unique perspectives. Graduate nurse educators consider how to prepare an expert practitioner and look at what behaviors the health care system expects of these expert clinicians. Nurse administrators wonder how the role of the CNS will be clarified within their organizations.

Organizational placement, scope of responsibility, and cost benefits are only some of the many concerns we must address if expert clinicians are to be used as effectively as possible. Clinical nurse specialists have had difficulty pointing out just what they can contribute to the system by providing safe, cost effective, and quality patient care. They must learn to sell the role to nurse administrators, physicians, nursing staff, other health professionals, and consumers, while holding onto their primary commitment, which is patient advocacy.

The idea of a clinical nurse specialist probably took shape during the second World War, when nurses had a great deal of authority and responsibility for patient care [1]. After the war, educational monies were available to students and for programs to provide opportunities at the bachelor's and master's levels. Clarifying the CNS role formally began 30 years ago, with the work of Dr. Hildegard Peplau at Rutgers: She developed the first graduate program to prepare advanced practitioners in psychiatric nursing. In the 60's and 70's, nursing leaders and nursing organizations continued to examine the role. In 1961, Frances Reiter first defined the CNS role in tasks using role-work analysis; and in 1969, the National League for Nursing published a document describing the role [2]. A Nursing Curriculum Project, sponsored by the Southern Regional Education Board in 1976, concluded that the CNS "works with the most complex problems in nursing, possesses advanced clinical knowledge, improves own practice, gives and demonstrates care, and plans and supervises staff education [3]." In its 1980 social policy statement, the American Nurses Association outlined its official position on educational preparation and practice expectations: "The specialist in nursing practice is a nurse who, through study and supervised practice at the graduate levels (master's or doctorate), has become expert in a defined area of knowledge and practice in a selected clinical area of nursing [4]."

Despite these efforts to pinpoint the role, issues such as titling, preparation needed, performance expectations, organizational fit, and the use of the specialists continue to cause confusion and force restraint in implementing the role. These issues, and the 30 years of questions surrounding the CNS role, prompted collaborative research by The University of Texas at Arlington (UTA) and Methodist Hospitals of Dallas (MHD) to investigate which competency behaviors nurse administrators, graduate nurse educators, and clinical nurse specialists see for clinical nurse specialists.

Both investigating institutions are

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The authors wish to acknowledge the help of Myrna R. Pickard, EdD, RN; Yvonne L. Munn, MSN, RN; Nancy L. Ackley, MS, RN; and Patsy L. Keyser, MS, RN; in preparing this article.

committed to the continued development of the CNS role as nursing's response to changes in health care delivery. UTA provides master's preparation for the CNS role and MHD (Dallas) uses clinical nurse specialists. We believed collaboration would yield higher-quality results by broadening the perspective, making access to sites and subjects easier, and providing a wider range for applying the findings.

We investigated these specific research questions:

1. What are the essential competency behaviors in the role of the CNS as perceived by nurse administrators, graduate nurse educators, and clinical nurse specialists?
2. Is there a difference in the perceptions of the nurse administrators, graduate nurse educators, and clinical nurse specialists regarding the competency behaviors of the CNS role?
3. What subroles make up the CNS role?

Methodology

We did a descriptive survey to identify the essential competency behaviors for the CNS role as perceived by nurse administrators, graduate nurse educators, and clinical nurse specialists. These three groups completed a questionnaire to rate the importance of 40 behaviors chosen by means of a pilot study.

We started by reviewing the literature and discussing the CNS role with nurse administrators, graduate nurse educators, and clinical nurse specialists to identify the behaviors most important to that role. The behaviors reflected these subroles: practitioner, teacher, consultant, researcher, change agent, and manager [12-14]. Seventy-five initial behaviors were sorted down to 40 by representative administrators, educators, and practitioners [15]. We then wrote a 40-item questionnaire to gather data from a national sample. Subjects completed the questionnaire by rating each of the 40 behaviors on a scale from 1 to 6, with 1 being the least necessary behavior.

The national sample included 527 subjects (see Table 1). Sixty-four percent of the administrators, who were all from hospitals with 400 beds or more, reported employing clinical nurse specialists — 23 percent employed 6 to 10; 7 percent employed 11 to 15; and 3 percent employed more than 15. Graduate nurse educators were from schools with National League for Nursing (NLN) accredited master's programs that offered courses to prepare specialists with clinical specializations in medical/surgical nursing (24 percent); psychiatric nursing (22 percent); maternal/child nursing (15 percent); pediatric nursing (10 percent); and other specialty areas. All of the clinical nurse specialists who participated in the study were master's prepared and were currently practicing or had practiced during the last two years. Thirty-seven percent of the specialists reported responsibility for a particular patient population, such as cardiovascular or respiratory; 28 percent had responsibility for a general nursing area; and 15 percent had responsibility for one specific unit.

Table 1
National Sample

Sample Group	Number of Subjects	Return Rate
Nurse Administrators	161	38%
Graduate Nurse Educators	233	49%
Clinical Nurse Specialists	133	61%
Total	527	49%

Results

Question 1. What are the essential competency behaviors in the role of the CNS as perceived by nurse administrators, graduate nurse educators, and specialists?

All of the 40 competency behaviors were considered essential by all three groups. Table 2 shows the means for each behavior for the nurse administrators, the graduate nurse educators, the clinical nurse specialists, and for the total sample. Developing an in-depth knowledge base, demonstrating clinical expertise in a selected area of clinical practice, and serving as a role model were the three behaviors considered most important by all three groups. Implementing the discharge process scored lowest for all three, either because the behavioral statement was narrowly interpreted or because clinical nurse specialists just start the discharge process and have a staff nurse, the patient's primary nurse, or a discharge planner follow it through.

Question 2. Is there a difference in the perceptions of the nurse administrators, graduate nurse educators, and clinical nurse specialists regarding the competency behaviors of the CNS role?

We found no significant difference among the three groups for all the behaviors collectively. For individual behaviors, the groups differed most regarding behaviors 1, 7, and 9. Among the three groups, nurse administrators and graduate nurse educators differed most; nurse administrators and clinical nurse specialists least.

Question 3. What subroles make up the CNS role?

From respondents' answers, we reduced the 40 behaviors to three subroles labeled practitioner/teacher, consultant, and researcher. Table 3 shows the subroles and identifies the behaviors they include. Our analysis did not show "manager" and "change agent" subroles, but behaviors for these were mixed throughout the others.

This investigation points out how nurse administrators, graduate nurse educators, and clinical nurse specialists see the CNS role. The findings show that these three groups do not differ significantly in their perceptions of the 40 behaviors studied, and that practitioner/teacher, consultant, and researcher subroles seem to be most representative of the CNS role.

These forty behaviors help clarify the CNS role for nurses, other health professionals, and consumers, and could promote the start-up of the role in a variety of health care settings. Study results can also guide nurse administrators to effectively use and evaluate the CNS. Guided by the behaviors, administrators can examine institutional factors — such as constraints on time, money, and personnel — to see if they

Table 2
Competency Behaviors and Group Means

COMPETENCY BEHAVIORS	BEHAVIORAL MEANS			
	Nurse Admin.	Grad. Nurse Educ.	Clin. Nurse Spec.	Total
1. Develops own conceptual framework for nursing practice.	4.53	4.95	4.62**	4.74
2. Practices within the A.N.A. ethical code.	5.18	5.49	5.31	5.35
3. Develops outcome criteria to evaluate patient care.	5.16	5.44	5.20	5.29
4. Uses a systematic process to make decisions.	5.49	5.62	5.55	5.57
5. Initiates change in the health care delivery system.	5.13	5.02	5.23	5.11
6. Initiates collaborative relationships to improve health care delivery.	5.46	5.39	5.38	5.41
7. Coordinates nursing personnel and nursing activities to accomplish patient goals.	4.30**	4.74**	4.71	4.60**
8. Implements the discharge process to promote continuity of care & optimal patient health.	4.28**	4.68**	4.43**	4.50**
9. Demonstrates expertise in the referral process and the use of community resources.	4.43**	4.95	4.44**	4.67
10. Works collaboratively to facilitate interdisciplinary health care.	5.33	5.35	5.26	5.33
11. Evaluates psychological health care needs of clients.	4.96	5.29	5.01	5.12
12. Provides consultation to effect improvement in individual client care delivery.	5.48	5.42	5.52	5.46
13. Coordinates clients' care within health care delivery system.	4.53	4.86	4.63	4.70
14. Evaluates the teaching and learning of clients.	5.06	5.16	4.86	5.05
15. Modifies patient care within the clinical setting.	5.13	5.12	5.14	5.13
16. Develops teaching aids to promote client learning.	4.67	4.42**	4.71	4.58**
17. Develops protocols for the clinical practice of nursing.	5.13	4.90	4.95	4.98
18. Identifies nursing problems for evaluative and/or scientific investigation.	5.18	5.46	5.09	5.28
19. Implements nursing actions which incorporate client health practices.	5.00	5.11	4.95	5.04
20. Reviews current literature of nursing theories and models to improve clinical practice.	5.08	5.13	5.06	5.10
21. Uses research findings to improve nursing practice.	5.35	5.67*	5.45	5.52
22. Provides information to promote patient health care choices.	5.05	5.25	5.23	5.19
23. Participates in research or scientific investigation.	4.92	5.13	4.96	5.03
24. Uses advanced data base in planning patient care.	5.37	5.48	5.40	5.43
25. Continues to develop an indepth knowledge base to promote patient care.	5.63*	5.69*	5.64*	5.66*
26. Promotes individualized patient care that reflects depth, breadth and continuity.	5.45	5.51	5.61	5.52
27. Promotes the teaching and learning of colleagues.	5.24	4.89	5.00	5.03
28. Uses appropriate teaching materials and strategies with clients.	5.07	5.08	5.15	5.10
29. Accepts personal accountability for patient care.	5.34	5.57	5.56	5.50

Table 2 (continued)
Competency Behaviors and Group Means

COMPETENCY BEHAVIORS	BEHAVIORAL MEANS			
	Nurse Admin.	Grad. Nurse Educ.	Clin. Nurse Spec.	Total
30. Assumes leadership to facilitate interdisciplinary collaboration.	5.34	5.36	5.38	5.35
31. Demonstrates clinical expertise in a selected area of clinical practice.	5.79*	5.79*	5.76*	5.78*
32. Uses evaluative tools to measure outcomes of nursing action.	5.15	5.33	5.02	5.20
33. Evaluates physical health care needs of clients.	4.95	5.20	4.97	5.07
34. Serves as a resource person to colleagues, and consumers of health care.	5.49	5.29	5.53	5.41
35. Functions within the laws which affect advanced nursing practice.	5.71*	5.54	5.57	5.60*
36. Provides consultation to patients.	5.17	5.31	5.50	5.32
37. Serves as a role model for advanced nursing practice.	5.78*	5.69*	5.76*	5.74*
38. Provides consultation to other members of health team.	5.34	5.36	5.43	5.37
39. Integrates own ethical code in practice of nursing.	5.30	5.55	5.65*	5.50
40. Identifies nursing diagnoses as a part of clinical practice and contributes to the formulation of new diagnoses.	5.17	5.08	5.12	5.12
Total	5.15	5.26	5.19	5.20

* Highest Means
** Lowest Means

Methodist Hospitals of Dallas/The University of Texas at Arlington

enhance or inhibit the CNS role. Nurse administrators can use the behaviors to review and modify existing CNS job descriptions to determine whether the specialist will work best in line or staff positions. And they can find the specific behaviors that would be valued and rewarded in their particular institutions.

Using these behaviors and subroles, graduate nurse educators can determine how to prepare the CNS; and they can develop theoretical and practical learning experiences that focus on accomplishing these behaviors. Students can integrate these 40 behaviors into subroles within their philosophy and framework for practice. A student's philosophy and framework will direct the care provided to patients and families and will influence the relationships developed with other health professionals. These behaviors can also be used to evaluate students' progress in courses or their development of the behaviors and subroles for the CNS role. Hopefully, the behaviors will encourage both faculty and students to clarify the CNS role through research and practice.

Clinical nurse specialists can use the competency behaviors to guide their practice and to make their role clear to nurse administrators, physicians, nursing staff, other health professionals, and consumers. The behaviors can be used as the standard criteria for peer and for personal review.

The behaviors can also help specialists implement and explain their subroles. The CNS as practitioner/teacher knows scientific and general nursing theory and can translate that theory into practice. As the role develops, more emphasis will be placed on patient outcomes and less on process. Evaluating physical and psychosocial health needs of clients; offering individualized patient- and family-care of depth, breadth, and continuity; and developing and using teaching aids will be important elements of care. Looking at lengths of stay, return to activities of daily living, use of community resources, and the frequency with which clients return to the hospital will determine the outcomes of that care. Once the process behaviors can be linked to specific patient outcomes, the CNS's role in producing those outcomes can be more easily communicated.

As a consultant, the CNS may be asked for answers to specific problems or may, in collaboration with nursing staff, make nursing diagnoses and generate solutions. In addition, the CNS may become the liaison between doctor's office, hospital, and home health agency in assuring cost effective, quality nursing care. Even now, clinical nurse specialists are providing or planning the intensive nursing care needed by the increasing numbers of sick clients cared for at home. The desired outcome of consultative behaviors with nurses and other health professions is the improvement of care delivery.

As a researcher, the CNS identifies problems for investigation, participates in research, and disseminates research findings. But there are difficulties for the CNS in conducting research, including time constraints, lack of funding, and lack of other CNS role models who are able to incorporate conducting research into their role. Doing research is essential for clinical nurse specialists to examine existing nursing care, and generate and refine interventions focused on patient outcomes.

Identifying competency behaviors was a continuation of the 30-year en-

Table 3
CNS Subroles and Behaviors

SUBROLES	BEHAVIORS
Practitioner/ Teacher (Factor 1)	7. Coordinates nursing personnel and nursing activities to accomplish patient goals.
	8. Implements the discharge process to promote continuity of care and optimal patient health.
	9. Demonstrates expertise in the referral process and the use of community resources.
	10. Works collaboratively to facilitate interdisciplinary health care.
	11. Evaluates psychological health care needs of clients.
	13. Coordinates clients' care within health care delivery system.
	14. Evaluates the teaching and learning of clients.
	15. Modifies patient care within the clinical setting.
	16. Develops teaching aids to promote client learning.
	19. Implements nursing actions which incorporate client health practices.
	22. Provides information to promote patient health care choices.
	26. Promotes individualized patient care that reflects depth, breadth and continuity.
	28. Uses appropriate teaching materials and strategies with clients.
	29. Accepts personal accountability for patient care.
	33. Evaluates physical health care needs of clients.
	36. Provides consultation to patients.
Consultant (Factor 2)	5. Initiates change in the health care delivery system.
	6. Initiates collaborative relationships to improve health care delivery.
	12. Provides consultation to effect improvement in individual client care delivery.
	27. Promotes the teaching and learning of colleagues.
	30. Assumes leadership to facilitate interdisciplinary collaboration.
	34. Serves as a resource person to colleagues, and consumers of health care.
	35. Functions within the laws which affect advanced nursing practice.
	37. Serves as a role model for advanced nursing practice.
	38. Provides consultation to other members of health team.
	39. Integrates own ethical code in practice of nursing.
Researcher (Factor 3)	18. Identifies nursing problems for evaluative and/or scientific investigation.
	20. Reviews current literature of nursing theories and models to improve clinical practice.
	21. Uses research findings to improve nursing practice.
	23. Participates in research or scientific investigation.
	24. Uses advanced data base in planning patient care.
	25. Continues to develop an in-depth knowledge base to promote patient care.
	32. Uses evaluative tools to measure outcomes of nursing action.

deavor to clarify the CNS role. Replication of this study is needed to determine if the perceptions of the nurse administrators, graduate nurse educators, and clinical nurse specialists were accurately reflected and if these perceptions change significantly over time. Another question for further research is whether fewer behaviors would yield just as useful results. Study is needed to determine the instrument's validity and to evaluate the instrument's reliability. And extensive research is needed on the accuracy of these behaviors and subroles in describing the CNS role and on the usefulness of these behaviors in education and practice. For example, studies might examine peer review and determine how to organize and implement a curriculum based on the 40 behaviors and 3 subroles. Research is also needed to determine the cost-effectiveness of the CNS role, because the future of the role revolves around the translation of the behaviors into specific patient outcomes. Our intent was to add to nursing's knowledge about the perceptions of the CNS role and to stimulate additional study of that role.

Readers interested in more detailed information on the study procedures should contact the authors through Nursing & Health Care.

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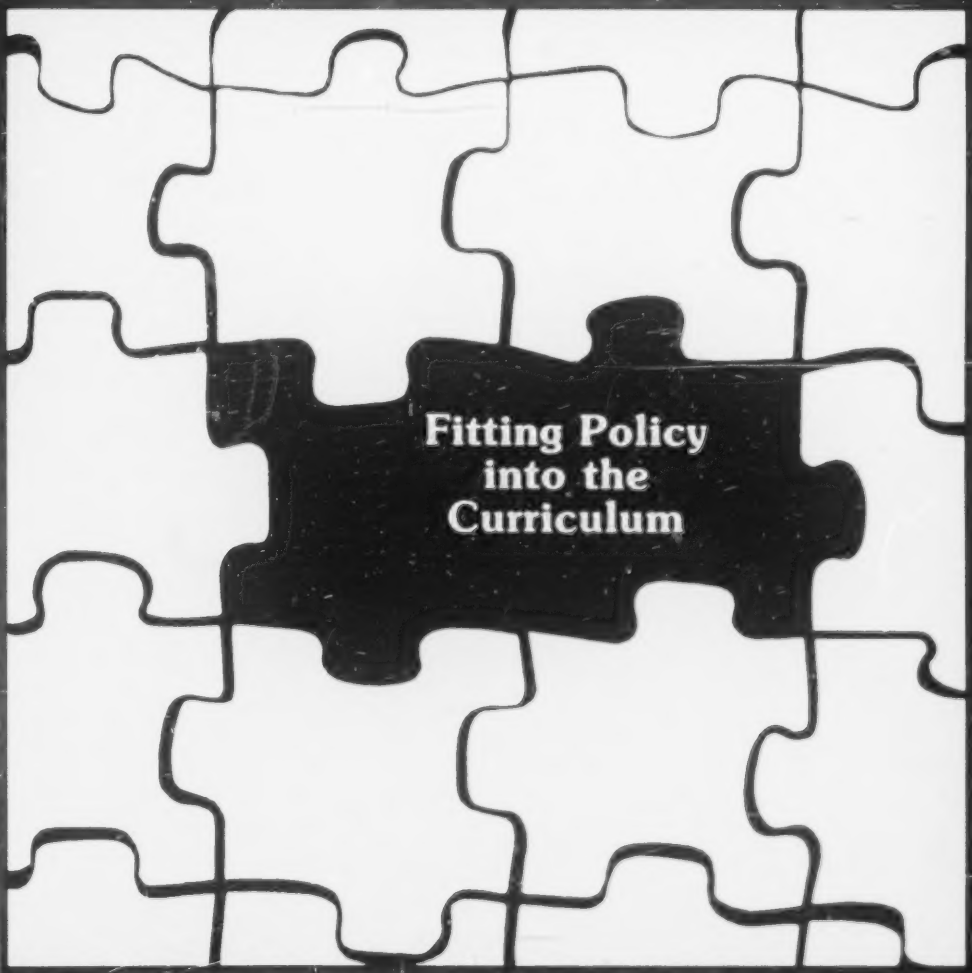

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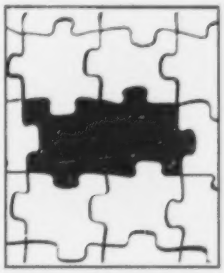
VOLUME 6, NUMBER 8 OCTOBER 1985

CONTENTS

Cover Story

Fitting Health Policy into Nursing Curricula



Health policy is neither mysterious nor difficult to teach, says author Donna Diers. In fact, it already exists in nursing curricula, and all nurses have to do is learn to recognize where. **Page 420.**

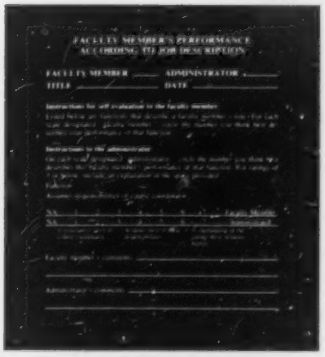
Features

434

DRGs and Nursing

In this close look at Diagnosis Related Groups, the authors say nurses are just beginning to see their implications for the profession.

John D. Thompson
Donna Diers



446

Successful Evaluation

Believing that most faculty appraisal is a hit or miss activity, the author describes a way to make it more worthwhile.

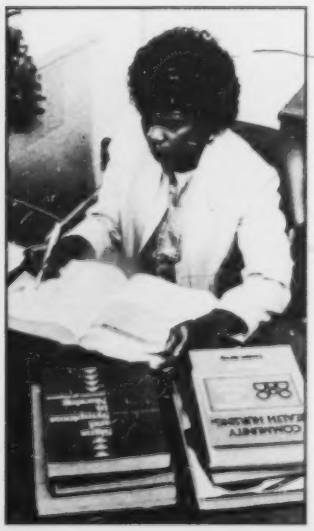
Margaret J. Sullivan

450

Faculty Evaluation Model

Evaluation should be more than an efficiency rating, says the author. Her college uses this model to stimulate individual growth.

Shirley A. Cudney



440

Textbook Selection

With the numbers of new nursing texts ever on the rise, the authors hope their process for choosing the best will ease the job for others.

Celia L. Hartley
Ann G. Ross

Departments

402 Announcements
403 Guest Editorial
405 NLN Perspective
408 NLN Mission and Goals
409 Adopted Resolutions
412 1984 Financial Statements
414 News
418 Washington Focus
458 NLN Calendar
459 Classified

Special in this issue: Program brochure for the Second NLN National Conference on Nursing Education — Patterns of Specialization: Challenge to the Curriculum. See page 425 for a look at the program and information on how to register.

NURSING & HEALTH CARE offers diverse views on subjects of interest to readers. Articles represent the opinions of individual contributing authors and are not necessarily those of the National League for Nursing.

Nurses Score Victory On Nurse Education Act *More Legislation Pending*

By Sally B. Solomon, MSN, RN
Director of Public Policy & Research, NLN

On August 16, President Reagan signed into law a bill that reauthorizes federal funding of nursing education for three years. His signature marks a triumphant end to months of planning and hard work on behalf of the Nursing Tri-Council — the League, the American Nurses' Association, and the American Association of Colleges of Nursing — as well as other nursing groups.

The new authorization bill sets funding levels for nursing education in fiscal year 1986 at $53.9 million, at $55.3 million in FY87, and at $56.6 million in FY88.

Although earlier authorization for nursing education ended in 1984, additional funds were granted under the authority of a continuing resolution, which is a temporary measure that provides continued funding for programs whose authorizations have expired.

As do all authorization bills, this legislation establishes categories and ceilings for funding. The actual amounts to be spent each year will be determined by the appropriations committees under the guidelines established by the authorization bill. For FY85, appropriations for nursing education were set at $50.3 million, with an additional $9.4 million for nursing research and $2.0 million for national research service awards for nursing fellowships.

The $54 million authorized for FY86 represents a modest increase over current appropriations levels; key players considered it a prudent amount in light of deficit reducing pressures. A breakdown of the bill over the next three years appears on this page.

The bill includes two new items — one for demonstration projects that will promote collaboration between nursing practice and education and will find ways to improve access to nursing services in noninstitutional settings, particularly in underserved areas; the other for post baccalaureate fellowships designed to allow nursing faculty to "investigate cost-effective alternatives to traditional health care modalities and. . . examine nursing interventions that result in positive outcomes in health status." The bill also includes amendments on nursing student loans that provide for: referral of loan collection to the government; an administrative law hearing before a school is removed from the loan program; IRS help in tracking delinquent borrowers; and a new, more lenient formula for determining student delinquency rates.

Nurses can breathe a sigh of relief with the passage of this bill. The mechanism is now in place for future appropriations for nursing education, and the president's signature shows administrative support for nursing education. The bill's passage also demonstrates how effective nurses can be in Washington when we unite on an issue.

Authorization for Federal Funding of Nursing Education

Category	FY86	FY87	FY88
Special Projects	9.5*	9.5	9.5
Demonstration Projects	2.7	2.7	2.7
Advanced Nurse Education	16.5	17.0	17.5
Advanced Nurse Traineeships	11.5	12.25	13.0
Nurse Practitioner Nurse Midwifery Programs	12.0	12.0	12.0
Post-Baccaulaureate Fellowships	1.1	1.1	1.1
Nurse-Anesthetists	0.8	0.8	0.8
TOTAL	54.1	55.3	56.6

** In millions of dollars*

With the authorization bill in place, appropriations for FY86 can proceed according to legislative protocol. Although appropriations for nursing education in FY86 will likely be frozen at current spending levels, funding for nursing research may increase, since it is administered under a different part of the Public Health Service Act, and is not subject to the same monetary ceiling as education. Both the House and the Senate appropriations committees have agreed to set aside $5 million for administrative costs in the event that legislation is enacted in FY86 that creates a new federal structure for nursing research.

National Institute of Nursing

The proposal to create a National Institute of Nursing (NIN) has emerged as one of the most controversial items in the National Institutes of Health (NIH) reauthorization bill. On June 17, the House passed an NIH bill that calls for establishing two new institutes, one for nursing research and one for arthritis research.

About one month later, the Senate passed an NIH bill with no provision for a nursing institute or for any other measures to promote nursing research at NIH. It does provide for establishing an arthritis institute. The bill had bipartisan support of Senator Orrin Hatch (R-Utah) and Senator Edward Kennedy (D-Massachusetts), chair and ranking minority member of the Senate Labor and Human Resources Committee, which has jurisdiction over NIH.

Although the nursing institute provision in the House bill is one of its most controversial features, both the House and Senate bills include high funding levels for NIH and call for close congressional scrutiny of the institutes. Because of these provisions, some experts on Capitol Hill think President Reagan may veto the NIH bill even if, in its final form, it does not provide for a nursing institute.

Senate awareness of and support for the nursing institute has grown since last year's first attempt to establish it. The Nursing Tri-Council is now focusing on the Senate in an effort to rally even more interest; we have been educating senators about the benefits of nursing research.

The two versions of the NIH bill will be referred to a joint Senate-House conference committee, which will work out the differences. Senate conferees, in addition to Senators Hatch and Kennedy, are Dan Quayle (R-Indiana), Don Nickles (R-Oklahoma), and Chris Dodd (D-Connecticut). Likely House conferees are Henry Waxman (D-California), Ed Madigan (R-Illinois), John Dingell (D-Michigan), James Broyhill (D-North Carolina), and James Scheuer (D-New York). When Congress has approved a final bill, it will be sent to the president for approval.

Medicare Revisions

The House Ways and Means Committee recently passed legislation that would revise parts of the Medicare program. Although the Senate has yet to vote on its comparible bill, Capitol Hill observers do not think there will be many substantive differences between legislation passed in both Houses.

Major provisions of the House bill are a 1 percent increase in Medicare DRG prices; a one-year freeze on the scheduled transition to a national DRG rate; cuts in the indirect teaching adjustment; a "special disproportionate share" adjustment for hospitals that treat a large volume of Medicaid and low-income Medicare patients; a one-year extension of the physician freeze; new demonstration projects to evaluate the cost-effectiveness of preventive services to Medicare beneficiaries; and a freeze on premiums for Part B, which covers physicians' services. In reporting the bill, the Ways and Means Committee also included a provision to increase the number of Prospective Payment Assessment Commission (ProPAC) commissioners from 15 to 23 by January, 1986. The Committee has recommended that two of the eight new appointees be reserved for representatives of rural hospitals and the nursing profession.

The Senate version of the bill includes a provision to increase the membership of ProPAC by two. Senate Majority Leader Robert Dole (R-Kansas), who introduced the provision, indicated that one of the new appointees should be a nurse. NLN and ANA are working with other groups to encourage appointing a nurse in active practice to ProPAC, which is especially important in light of ProPAC's congressional directive to examine the effects of prospective payment on nursing care.